Sentara®
Health Plans

How To Submit Reconsiderations, Corrected Claims, and Appeals

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(this document is interactive)

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General Information and Filing Requirements – Rendering and/or Billing Provider

The preferred method for claim submission to Sentara Health Plans is electronic claim submission. Claims can be submitted through Availity or any clearinghouse that can connect through Availity.

All claims must be submitted within the guidelines of the product (see the "timely filing" section in this chapter), or they will be denied as a late claim submission.

Claims submitted must be for participating providers within the practice. Submit paper claims on the standard CMS 1500 form for professional providers or UB-04 form for facilities. All claims must be "clean claims."

In order to process a claim, we require a valid W-9 for the provider tax identification number (TIN) on file with Sentara Health Plans. We may require that any claim submitted without a valid W-9 on file be resubmitted in order to be processed.

Claims submitted without a W-9 may be rejected by a clearinghouse or Sentara Health Plans or administratively denied.

Claim Reconsideration Overview

- A claim reconsideration is defined as a payment dispute (paid or denied) that a provider would like to have reviewed for further consideration.
- Providers have 365 days from the last date of service to submit a timely reconsideration.
  - Nonpar Medicare providers have 60 days from last remittance date and must submit a waiver of liability with reconsideration.
  - All claim reconsiderations should be submitted through:
    - **Mail** on a Sentara Health Plans **Provider Reconsideration Form** for medical claims or **Behavioral Health Provider Reconsideration Form** for behavioral health.
    - **Reconsidertion Portal** (Medicaid and Medicare only)
  - One claim inquiry should be submitted per form.

Commercial member reconsiderations can only be mailed.

Claim Reconsideration Tiered Review Process

Sentara follows a two-tiered escalation process for claim payment disputes.

1. First level reconsiderations are reviewed by the Sentara claims reconsideration specialist.
2. Second level reconsiderations are reviewed by an alternate team member from the first level submission.
    - If the original claim decision is to be overturned, the claim will be reprocessed and updated remittance will be the notification to the provider that item processed favorably.
    - If the original decision stands, the provider will receive an uphold letter indicating reason(s) why and next steps to have claim further reconsidered.
    - Each subsequent submission has a 60-day follow-up period from the last remittance/decision letter date when submitting a follow-up reconsideration.
        - Additional escalations must continue to be submitted using the **Provider Reconsideration Form** or the **Behavioral Health Provider Reconsideration Form**, notating the level of escalation (i.e., first or second level reconsideration).
        - After a second level reconsideration submission has been upheld, all reconsideration rights at Sentara Health Plans will be considered exhausted. Next steps would be to submit an appeal to the Department of Medical Assistance Services (DMAS) for further review. Steps to complete this process will be listed in the uphold letter submitted to the provider.

Commercial plans do not have appeal rights with DMAS. Please see Commercial Provider Manual for appeal rights.

Claim Reconsideration vs. Corrected Claim

A claim reconsideration is **not a corrected claim**. Corrected claims are to be submitted through the same channels as an original claim submission. Please use the link below for additional information. Corrected claims can be submitted online through the provider portal for changes to CPT code, diagnosis, billed charges, quantity, and/or place of service.

Corrected Claim Submission of a Previously Billed Claims

A corrected claim is a replacement of a previously submitted claim that requires changes or correction to the charges, clinical or procedures codes, dates of service, member information etc.

Corrected Claim Submission of a Previously Billed Claim UB-04 Claims

- Bill type is a key indicator to determine whether a claim has been previously submitted and processed.
- The first digit of the bill type indicates the type of facility.
- The second digit indicates the type of care provided.
- The third digit indicates the frequency of the bill.
- Billing type is important for interim billing or a replacement/resubmission bill.
- "Resubmission" should be indicated in block 80 or any other unoccupied block of the UB-04.

Corrected Claim Submission of a Previously Billed CMS-1500 Claims

- Claims submitted for correction require a "7" in box 22.
- Claims that need to be voided require an "8" in box 22.
- Enter the original claim number of the claim you are replacing in the right side of item 22.

Claim Reconsideration vs. Appeal

A claim reconsideration is **not an appeal** at Sentara Health Plans. Appeals can be submitted when an authorization for a service has been denied by the utilization management department.

To submit an appeal per line of business, please review the information in the link below.

Provider Appeals Procedure

Claim Reconsideration vs. Provider Services

All providers are encouraged to contact provider services at **1-800-229-8822**, option 2, if a disputed claim is not responded to within 60 days of submission.

Representatives may be able to assist with the following claim inquiries:

- Verifying status
- Researching issues and denials

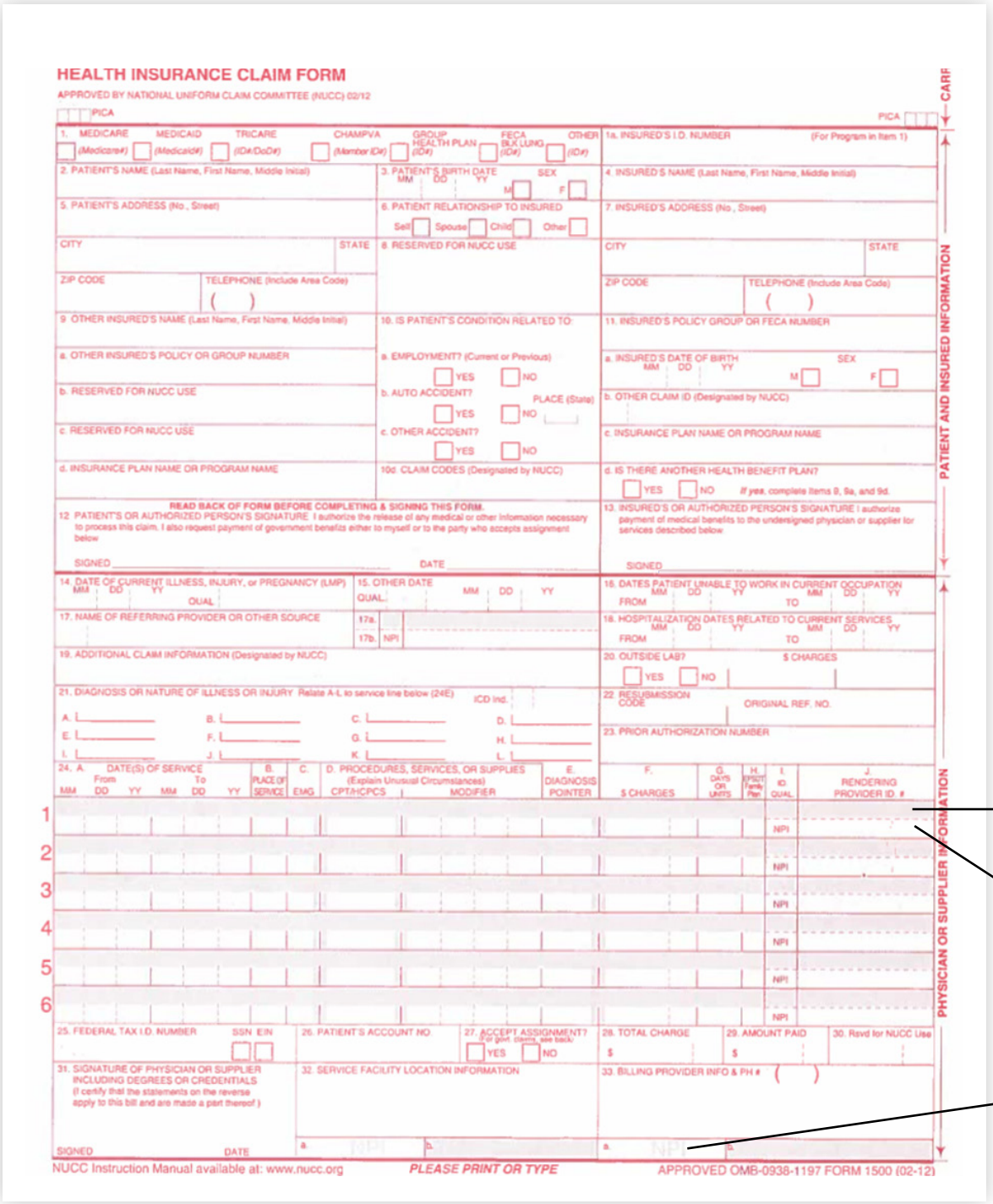
In cases where a provider issue is not resolved by provider services or there are additional questions related to the submission or standards for reconsiderations, providers should contact their provider services representative directly or their network educator at **contactmyrep@sentara.com**. Contact information can be found using the link below.

Go to **sentarahealthplans.com/providers/contact-us** and choose Provider Services.

Avoiding Common Claim Submission Errors

Please ensure claims contain:

1. Correct member name – the patient name on the claim must match the patient name as listed on the member ID card.
2. Correct date of birth.
3. Member ID number, including:
    - Member suffix: member number on claim must contain the correct two-digit suffix that identifies the patient
    - Complete member ID number
    - No asterisk or spaces
4. Providers offering multiple services and multiple provider setups must bill the appropriate NPI/tax ID on the claim to eliminate assignment logic delays.
5. Rendering/Individual NPI should be listed in box 24J, "Rendering Provider ID #," in the bottom unshaded portion of the box labeled "NPI."
6. Taxonomy code should be listed in the top shaded portion of box 24J. Claims submitted without the correct taxonomy code will be rejected or denied.
7. Billing/Group NPI should be listed in box 33a, "Billing Provider Info & PH #."
8. Services requiring pre-authorization can be found on **sentarahealthplans.com/providers**. If unsure, contact provider services at **757-552-7474** or **1-800-229-8822**.
9. Coordination of Benefits, Sentara Health Plans as secondary carrier. Claims must be submitted with Explanations of Benefits (EOBs) attached and the identical information included on the original claim.
    - Providers may not bill one insurance carrier for one charge amount and Sentara Health Plans for a different charge amount.
    - If a claim is filed for a member whose primary insurance is not Sentara Health Plans, the provider must submit an EOB for the claims within 18 months of the date of service.
10. Nonpar provider. After the Coordination of Care period, providers must secure a dually executed contract to participate with Sentara Health Plans and service Sentara Health Plans members. For more information on joining the network, please visit our **website**.
11. Please note: Timely filing deadline on all claims is 365 days from the date of service. This includes any corrections, reconsiderations, and/or appeals.



Taxonomy Code

Individual NPI
Box 24J

Group NPI
Box 33a

Claim Reconsideration Links

- **Provider Reconsideration Form**
- **Behavioral Health Provider Reconsideration Form**
- **Waiver of Liability Statement**

Mailing Addresses

Claims

Mail Paper Claims, Corrected Paper Claims, and Reconsiderations

Medical Claims:
PO Box 8203
Kingston, NY 12402-8203

Behavioral Health Claims:
PO Box 8204
Kingston, NY 12402-8204

Appeals

Sentara Health Plans Appeals & Grievances
PO Box 62876
Virginia Beach, VA 23466

Glossary

Appeal - An appeal is a formal request to reconsider and change a previous adverse decision when Sentara Health Plans has determined that the original payment was properly adjudicated and the provider continues to dispute the payment.

Corrected claim – A 're-billed" or "corrected claim" is a claim being resubmitted by the provider to correct or change a previous submission for the same patient, date of service, and/or procedures.

Electronic claim – An electronic claim is any medical claim created entirely via digital means, without any paper or printing, usually within medical software that includes a medical practice management system (PMS).

Electronic funds transfer (EFT) - An electronic funds transfer is the electronic transfer of money between people, banks, and companies.

Reconsideration - A reconsideration is a written notification from the provider indicating their request to review how a claim is processed. No changes to the claim are being made.

Timely filing – Timely filing is the time frame within which healthcare providers or medical billing companies should submit claims to insurance companies for reimbursement. Sentara Health Plans policy: All claims are to be submitted within one year, 365 days, of the date of service. This includes first time submission claims and claims that have been previously paid or denied (reconsideration). Sentara Health Plans allows 18 months from the date of service to coordinate benefits.